Questionnaire for Seizure History

Child's Name _____ Birthdate _____ Grade _____

Please answer all questions. Use the back of this form for additional information.

When was your child diagnosed with seizure disorder?

What type of seizure does your child experience?

What symptoms does your child experience during a seizure?

Is your child aware of an aura (distortion in vision, hearing, or smell) before a seizure?

Does your child remember conscious things during a seizure? ☐ No ☐ Yes

How often does your child experience a seizure? ☐ Daily ☐ Weekly ☐ Monthly ☐ Other

How long does your child's seizure typically last?

When was your child's last seizure (date/time)?

Has your child experienced a seizure lasting longer than five minutes? ☐ No ☐ Yes (Please explain)

Has your child gone to the emergency room or been hospitalized for his/her seizures? ☐ No ☐ Yes (Please explain)

What events might trigger a seizure?

What medications does your child take to manage his/her seizure disorder?

Name of medication _____ Amount _____ When taken _____

Name of medication _____ Amount _____ When taken _____

Name of medication _____ Amount _____ When taken _____

Has your child been instructed to take medications independently? ☐ No ☐ Yes

Are there any side effects of your child's medications that his/her teacher needs to be aware of? ☐ No ☐ Yes

(Please explain)

Is your child participating in sports or school activities? ☐ No ☐ Yes (Please explain)

Is your child comfortable alerting others when experiencing symptoms of a possible seizure? ☐ No ☐ Yes

Does your child wear a "medical alert" necklace/bracelet? ☐ No ☐ Yes

Describe your child's understanding of his/her seizure disorder: ☐ None ☐ Limited ☐ Basic ☐ Good

Has your medical provider indicated in writing that your child needs special accommodations in school?

☐ No ☐ Yes (Please explain)

Information provided by _____ Date _____